APPLICATION FOR CLINICAL PRIVILEGES/MEDICAL STAFF APPOINTMENT

AUTHORITY: Title 10, U.S.C. Chapter 55, Sections 1094 and 1102.
PRINCIPAL PURPOSE: To evaluate professional criteria for medical staff membership and clinical privileges; designed to help establish an applicant's background, current competence, and physical and mental ability to discharge patient care responsibilities. This evaluation is essential to establishing and maintaining a qualified, competent medical staff.
ROUTINE USE: Information on this form may be released to government boards or agencies, or to professional societies or organizations, if needed to license or monitor professional standards of health care providers. It may also be released to civilian medical institutions or organizations where the provider is applying for staff privileges during or after separating from the Air Force.
DISCLOSURE IS VOLUNTARY: However, failure to provide information may result in the limitation or termination of clinical privileges.

APPLICANT COMPLETES SECTIONS I THROUGH X

I. IDENTIFICATION *(All date entries must be entered as MM/DD/YYYY)*

NAME *(Last, First, Middle Name)* **ALIAS** *(i.e., Maiden)*	**DATE OF BIRTH**	**GRADE**	**SSN**	**DATE**

HOME ADDRESS *(City, State, and Zip Code)*	**HOME PHONE**	**DUTY PHONE**	**EMAIL ADDRESS**

ORGANIZATION/OFFICE SYMBOL	**DUTY SECTION**	**DAFSC**	**PAFSC**	**CORPS**

SOURCE OF ACCESSION:

- ☐ Baccalaureate Degree Completion Program (BDCP)
- ☐ Direct Accession (DA)
- ☐ Enlisted Commissioning Program (ECP)
- ☐ Financial Assistance Program (FAP)
- ☐ Health Professional Scholarship Program (HPSP)
- ☐ Reserve Officer Training Corps (ROTC)
- ☐ Uniformed Services Univ. of Health Sciences (USUHS)
- ☐ National Guard
- ☐ Reserve
- ☐ Foreign National
- ☐ Civilian Civil Service
- ☐ Civilian Contractor
- ☐ Civilian Consultant
- ☐ Civilian Volunteer
- ☐ Other:

II. PROFESSIONAL EDUCATION *(Undergraduate/Graduate/Professional)*

NAME OF PROFESSIONAL SCHOOL	**LOCATION**	**DATES ATTENDED**		**DEGREE**
		FROM	**TO**	

III. POST GRADUATE TRAINING *(Internship, Residency, Fellowship)*

NAME OF INSTITUTION	**LOCATION**	**TYPE OF PROGRAM** *(Residency, etc.)*	**DATES ATTENDED**	
			FROM	**TO**

IV. PRESENT AND PREVIOUS MILITARY AND CIVILIAN ASSIGNMENTS *(If additional space is needed, continue on Page 2)*

NAME OF MEDICAL TREATMENT FACILITY (MTF) OR ORGANIZATION	**LOCATION**	**SERVICE OR SPECIALTY TO WHICH ASSIGNED**	**DATES ASSIGNED**	
			FROM	**TO**

APPLICATION FOR CLINICAL PRIVILEGES/MEDICAL STAFF APPOINTMENT *(Continued)*

IV. PRESENT AND PREVIOUS MILITARY AND CIVILIAN ASSIGNMENTS *(Continued)* *(If additional space is needed, continue in Remarks, Page 4)*

NAME OF MEDICAL TREATMENT FACILITY (MTF) OR ORGANIZATION	LOCATION	SERVICE OR SPECIALTY TO WHICH ASSIGNED	DATES ASSIGNED	
			FROM	TO

V. LICENSE/CERTIFICATION/REGISTRATION, SPECIALTY, AND FEDERAL DEA/STATE CSR *(If additional space is needed, continue in Remarks, Page 4)*

LICENSE/CERTIFICATION/REGISTRATION *(Must list **ALL** ever held.)*

STATE LICENSE *(Name of State)*	LICENSE NUMBER	DATE ISSUED	EXPIRATION DATE
NATIONAL CERTIFICATION	**CERTIFICATE NUMBER**	**DATE ISSUED**	**EXPIRATION DATE**
NATIONAL REGISTRATION	**REGISTRATION NUMBER**	**DATE ISSUED**	**EXPIRATION DATE**

SPECIALTY DATA

SPECIALTY *(List all specialties for which fully qualified)*

BOARD CERTIFICATION *(Specialty Board)*	CERTIFICATE NUMBER	DATE ISSUED	EXPIRATION DATE

FEDERAL DRUG ENFORCEMENT ADMINISTRATION (DEA)/STATE CONTROLLED SUBSTANCE REGISTRATION (CSR)

FEDERAL DEA *(Type)*	REGISTRATION NUMBER	DATE ISSUED	EXPIRATION DATE
DoD Fee-Exempt			
Federal (Fee-Paid)			
STATE CSR *(Name of State)*	**REGISTRATION NUMBER**	**DATE ISSUED**	**EXPIRATION DATE**

VI. MEMBERSHIP IN PROFESSIONAL SOCIETIES *(If additional space is needed, continue in Remarks, Page 4)*

NAME OF SOCIETY	STATUS *(Member, Fellow, etc.)*

VII. REFERENCES *(Every applicant MUST list three references: former clinical supervisor; chief, medical staff (SGH); and peer) (List email address if available)*

NAME	ADDRESS *(City/Base, State, Zip Code)*	TELEPHONE/EMAIL ADDRESS
		( ) –
		( ) –
		( ) –

APPLICATION FOR CLINICAL PRIVILEGES/MEDICAL STAFF APPOINTMENT *(Continued)*

VIII. PRACTICE HISTORY *(Explain all "yes" responses in Remarks, Page 4)*

	YES	NO
A. Have there been previously successful or currently pending challenges, revocations, or restrictions to any license, certification, or registration (state, district or Drug Enforcement Administration) to practice in any jurisdiction, or the voluntary/involuntary relinquishment of such license, certification, or registration?	☐	☐
B. Have you ever had a voluntary or involuntary limitation, reduction, revocation, suspension, denial, or loss of clinical privileges?	☐	☐
C. Have you ever voluntarily or involuntarily terminated or been denied medical staff membership or membership in a professional group or society?	☐	☐
D. Have you ever been a defendant in a felony or a misdemeanor case? *(Indicate final disposition of case in Remarks, Page 4)*	☐	☐
E. Have you ever been a defendant or the subject of a medical malpractice liability claim, settlement, judicial or administrative adjudication, or any other resolved or unresolved allegations of inappropriate, unethical, unprofessional, or substandard care?	☐	☐
IF "YES" WAS THE RESPONSE:		
(1) Settled prior to final court action?	☐	☐
(2) Judgment rendered by the court?	☐	☐
(3) Defendant found liable?	☐	☐
(4) Matter still pending?	☐	☐

IX. HEALTH STATUS *(Explain all "yes" responses in Remarks, Page 4)*

	YES	NO
A. Do you currently have any physical or mental impairment that could limit your clinical practice?	☐	☐
B. Are you currently taking any medications?	☐	☐
C. Do you have a potentially communicable disease?	☐	☐
D. Have you ever been hospitalized for any reason in the past 5 years?	☐	☐
E. Have you ever been hospitalized for, or diagnosed with, a psychiatric disorder to include substance abuse?	☐	☐
F. Are you currently under or have you ever received treatment for an alcohol or drug-related condition?	☐	☐
G. Have you ever used a controlled substance that was not prescribed for you by a physician or other health care provider?	☐	☐

X. STATEMENT OF APPLICANT *(PLEASE READ CAREFULLY BEFORE SIGNING)*

I certify all information submitted by me in this application is true to the best of my knowledge and belief and I have the ability to perform the clinical privileges requested.

I certify that any false or incomplete information knowingly provided on or with this application may be grounds either for not employing or accessing me or for dismissing or releasing me if I am already employed or serving. I understand that knowingly providing false or incomplete information is punishable by fine or imprisonment under United States Code Title 18, Section 1001.

I understand and agree that I, as an applicant for clinical privileges, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics, and other qualifications and for resolving any doubts about such qualifications.

I authorize all who may have information bearing on my professional qualifications, ethical standing, competence, and mental and physical health status to release the aforementioned information to the designated healthcare organization, their staff, and agents. This includes individuals, institutions, and entities of organizations with which I am currently or have been associated, and all professional liability insurers with which I have had or currently have professional liability insurance.

I consent to the inspection of all records and documents pertinent to my licensure, specific training, experience, current competence, and ability to perform the privileges requested, and, if requested, appear for an interview.

I agree to release and hold harmless from any liability the United States and any and all persons who participate within the scope of their duties in good faith and without malice in the review of any action or recommendation relating to my application.

In making this application for clinical privileges, I acknowledge my responsibility to provide for the continuous care of my patients.

I have been informed that the medical staff bylaws, rules, and regulations *(AFI 44-119, Clinical Performance Improvement)* can be accessed at the following internet site: http://www.e-publishing.af.mil/ and agree that my activities as a medical staff member will be bound by these bylaws.

I acknowledge that I am familiar with the principles and standards of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and will cooperate in maintaining JCAHO standards.

I agree to subject my clinical performance to, and faithfully participate in, activities to measure, assess, and improve performance on an organization-wide basis.

SIGNATURE OF APPLICANT	DATE

APPLICATION FOR CLINICAL PRIVILEGES/MEDICAL STAFF APPOINTMENT *(Continued)*

FOR CREDENTIALS FUNCTION USE ONLY

TYPE OF CLINICAL PRIVILEGES

☐ **Regular Privileges** ☐ **Supervised Privileges** ☐ **Temporary Privileges**

TYPE OF MEDICAL STAFF APPOINTMENT

☐ **Initial-Active Medical Staff Appointment** ☐ **Active Medical Staff Appointment** ☐ **No Medical Staff Appointment**
☐ **Initial-Affiliate Medical Staff Appointment** ☐ **Affiliate Medical Staff Appointment** ☐ **Temporary Medical Staff Appointment**

XI. CLINICAL SUPERVISOR RECOMMENDATION

I have reviewed the provider's clinical privileges and confirm his/her physical and mental ability and qualifications to perform the requested privileges.

CLINICAL PRIVILEGES:	☐ **Approval**	☐ **Approval with Modification** [1]	☐ **Disapproval** [1]
MEDICAL STAFF APPOINTMENT:	☐ **Approval**	☐ **Approval with Modification** [1]	☐ **Disapproval** [1]

SIGNATURE OF CLINICAL SUPERVISOR *(USE NAME STAMP OR TYPE NAME AND TITLE)* | **DATE**

XII. DEPARTMENT CHAIR / CHIEF OF SERVICE RECOMMENDATION

CLINICAL PRIVILEGES:	☐ **Approval**	☐ **Approval with Modification** [1]	☐ **Disapproval** [1]
MEDICAL STAFF APPOINTMENT:	☐ **Approval**	☐ **Approval with Modification** [1]	☐ **Disapproval** [1]

SIGNATURE OF DEPARTMENT CHAIR / CHIEF OF SERVICE *(USE NAME STAMP OR TYPE NAME AND TITLE)* | **DATE**

XIII. CREDENTIALS FUNCTION CHAIRPERSON (SGH) RECOMMENDATION

CLINICAL PRIVILEGES:	☐ **Approval**	☐ **Approval with Modification** [1]	☐ **Disapproval** [1]
MEDICAL STAFF APPOINTMENT:	☐ **Approval**	☐ **Approval with Modification** [1]	☐ **Disapproval** [1]

SIGNATURE OF CREDENTIALS FUNCTION CHAIRPERSON *(USE NAME STAMP OR TYPE NAME AND TITLE)* | **DATE**

XIV. MEDICAL FACILITY COMMANDER APPROVAL

☐ **Approved** ☐ **Approved with Modification** [1] ☐ **Disapproved** [1]

SIGNATURE OF MEDICAL FACILITY COMMANDER *(USE NAME STAMP OR TYPE NAME AND TITLE)* | **DATE**

REMARKS *(If additional space is needed, continue on plain bond paper)*:

(NOTE:1 Explain in "Remarks" on this page)